

INFANCY: 6 MONTHS

PARENT TO COMPLETE ABOUT THE CHILD	CHILD'S NAME		BROUGHT IN BY:		DATE OF BIRTH	
	ALLERGIES			CURRENT MEDICATIONS		
	ILLNESSES/ACCIDENTS/PROBLEMS/CONCERNS SINCE LAST VISIT				TODAY I HAVE A QUESTION ABOUT:	
	YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	My baby eats some solid foods.	<input type="checkbox"/>	<input type="checkbox"/>	My baby can pick up objects.	
<input type="checkbox"/>	<input type="checkbox"/>	My baby says things like "da da" or "ba ba."	<input type="checkbox"/>	<input type="checkbox"/>	My baby seems happy.	
<input type="checkbox"/>	<input type="checkbox"/>	My baby sits with help/support.	<input type="checkbox"/>	<input type="checkbox"/>	My baby recognizes me.	
<input type="checkbox"/>	<input type="checkbox"/>	I do not have frequent times of sadness.				

WEIGHT KG./OZ. PERCENTILE	HEIGHT CM/IN. PERCENTILE	HEAD CIR. PERCENTILE	Diet _____
---------------------------	--------------------------	----------------------	------------

<input type="checkbox"/> Review of systems <input type="checkbox"/> Review of family history <hr/> <hr/> <p>Screening:</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 150px;"></td> <td style="width: 50px; text-align: center;">N</td> <td style="width: 50px; text-align: center;">A</td> <td style="width: 100px;"></td> </tr> <tr> <td>Hearing</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td><hr/></td> </tr> <tr> <td>Vision</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td><hr/></td> </tr> </table> <p>Development: Circle area of concern</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 150px;">Adaptive/Cognitive</td> <td style="width: 150px;">Language/Communication</td> </tr> <tr> <td>Gross Motor</td> <td>Social/Emotional</td> </tr> <tr> <td>Fine Motor</td> <td></td> </tr> </table> <table border="0" style="width: 100%;"> <tr> <td style="width: 150px;">Behavior</td> <td style="width: 50px; text-align: center;"><input type="checkbox"/></td> <td style="width: 50px; text-align: center;"><input type="checkbox"/></td> <td style="width: 100px;"><hr/></td> </tr> <tr> <td>Mental Health</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td><hr/></td> </tr> </table> <p>Physical:</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 150px;"></td> <td style="width: 50px; text-align: center;">N</td> <td style="width: 50px; text-align: center;">A</td> <td style="width: 150px;"></td> <td style="width: 50px; text-align: center;">N</td> <td style="width: 50px; text-align: center;">A</td> </tr> <tr> <td>General appearance</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Chest</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Skin</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Lungs</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Head/Fontanelle</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Cardiovascular/Pulses</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Eyes (Cover/Uncover)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Abdomen</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Ears</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Genitalia</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Nose</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Spine</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Oropharynx</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Extremities</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Neck</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Neurologic</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Nodes</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td></td> <td></td> </tr> </table> <p>Describe abnormal findings and comments:</p> <hr/> <hr/> <hr/>		N	A		Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>	Vision	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>	Adaptive/Cognitive	Language/Communication	Gross Motor	Social/Emotional	Fine Motor		Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>	Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>		N	A		N	A	General appearance	<input type="checkbox"/>	<input type="checkbox"/>	Chest	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Head/Fontanelle	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular/Pulses	<input type="checkbox"/>	<input type="checkbox"/>	Eyes (Cover/Uncover)	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	Ears	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	Nose	<input type="checkbox"/>	<input type="checkbox"/>	Spine	<input type="checkbox"/>	<input type="checkbox"/>	Oropharynx	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Neck	<input type="checkbox"/>	<input type="checkbox"/>	Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	Nodes	<input type="checkbox"/>	<input type="checkbox"/>				<p>Elimination _____</p> <p>Sleep _____</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Review Immunization Record</td> <td style="width: 50%;"><input type="checkbox"/> Lead exposure</td> </tr> <tr> <td><input type="checkbox"/> Fluoride Supplements</td> <td><input type="checkbox"/> Fluoride Varnish <input type="checkbox"/> Hct/Hgb</td> </tr> </table> <p>Health Education: (Check all discussed/handouts given)</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Family Planning</td> <td style="width: 33%;"><input type="checkbox"/> Safety</td> <td style="width: 33%;"><input type="checkbox"/> Infant Temperament</td> </tr> <tr> <td><input type="checkbox"/> Development</td> <td><input type="checkbox"/> Crib Safety</td> <td><input type="checkbox"/> Shaken Baby Syndrome</td> </tr> <tr> <td><input type="checkbox"/> No Bottle in Bed</td> <td><input type="checkbox"/> Feeding</td> <td><input type="checkbox"/> Fever</td> </tr> <tr> <td><input type="checkbox"/> Teething/Dental</td> <td><input type="checkbox"/> Bedtime ritual</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Language Stimulation</td> <td><input type="checkbox"/> Stranger Anxiety</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Appropriate Car Seat</td> <td><input type="checkbox"/> Child care</td> <td><input type="checkbox"/> Passive Smoke</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Other: _____</td> </tr> </table> <p>Assessment/Plan:</p> <hr/> <hr/> <hr/> <hr/> <hr/>	<input type="checkbox"/> Review Immunization Record	<input type="checkbox"/> Lead exposure	<input type="checkbox"/> Fluoride Supplements	<input type="checkbox"/> Fluoride Varnish <input type="checkbox"/> Hct/Hgb	<input type="checkbox"/> Family Planning	<input type="checkbox"/> Safety	<input type="checkbox"/> Infant Temperament	<input type="checkbox"/> Development	<input type="checkbox"/> Crib Safety	<input type="checkbox"/> Shaken Baby Syndrome	<input type="checkbox"/> No Bottle in Bed	<input type="checkbox"/> Feeding	<input type="checkbox"/> Fever	<input type="checkbox"/> Teething/Dental	<input type="checkbox"/> Bedtime ritual		<input type="checkbox"/> Language Stimulation	<input type="checkbox"/> Stranger Anxiety		<input type="checkbox"/> Appropriate Car Seat	<input type="checkbox"/> Child care	<input type="checkbox"/> Passive Smoke	<input type="checkbox"/> Other: _____		
	N	A																																																																																																														
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>																																																																																																													
Vision	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>																																																																																																													
Adaptive/Cognitive	Language/Communication																																																																																																															
Gross Motor	Social/Emotional																																																																																																															
Fine Motor																																																																																																																
Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>																																																																																																													
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>																																																																																																													
	N	A		N	A																																																																																																											
General appearance	<input type="checkbox"/>	<input type="checkbox"/>	Chest	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																											
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																											
Head/Fontanelle	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular/Pulses	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																											
Eyes (Cover/Uncover)	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																											
Ears	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																											
Nose	<input type="checkbox"/>	<input type="checkbox"/>	Spine	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																											
Oropharynx	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																											
Neck	<input type="checkbox"/>	<input type="checkbox"/>	Neurologic	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																											
Nodes	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																														
<input type="checkbox"/> Review Immunization Record	<input type="checkbox"/> Lead exposure																																																																																																															
<input type="checkbox"/> Fluoride Supplements	<input type="checkbox"/> Fluoride Varnish <input type="checkbox"/> Hct/Hgb																																																																																																															
<input type="checkbox"/> Family Planning	<input type="checkbox"/> Safety	<input type="checkbox"/> Infant Temperament																																																																																																														
<input type="checkbox"/> Development	<input type="checkbox"/> Crib Safety	<input type="checkbox"/> Shaken Baby Syndrome																																																																																																														
<input type="checkbox"/> No Bottle in Bed	<input type="checkbox"/> Feeding	<input type="checkbox"/> Fever																																																																																																														
<input type="checkbox"/> Teething/Dental	<input type="checkbox"/> Bedtime ritual																																																																																																															
<input type="checkbox"/> Language Stimulation	<input type="checkbox"/> Stranger Anxiety																																																																																																															
<input type="checkbox"/> Appropriate Car Seat	<input type="checkbox"/> Child care	<input type="checkbox"/> Passive Smoke																																																																																																														
<input type="checkbox"/> Other: _____																																																																																																																

<hr/> <hr/> <hr/>	<p>IMMUNIZATIONS GIVEN</p> <hr/> <p>REFERRALS</p> <hr/>
-------------------	---

NEXT VISIT: 9 MONTHS OF AGE	HEALTH PROVIDER NAME
HEALTH PROVIDER SIGNATURE	HEALTH PROVIDER ADDRESS

INFANCY: 6 MONTHS

Your Baby's Health at 6 Months

Milestones

Ways your baby is developing between 6 and 9 months of age.

Says sounds such as "ba-ba-ba" and "dada."

Holds small things in her fist, then between her fingers.

Puts things in her mouth, can feed herself small pieces of soft food.

Sits up well.

Stands with support.

Moves across the floor on tummy, starts to crawl.

May start to act shy with strangers.

You help your baby learn new skills by playing with her.

For Help or More Information

Toy and Baby Product Safety: Consumer Product Safety Commission,
1-800-638-2772 (voice) or
1-800-638-8270 (TTY Relay)

Learn infant and child CPR and first aid:

Ask about classes at your local fire station, American Red Cross or Heart Association chapter, or health department.

Child health and development, immunizations: Healthy Mothers, Healthy Babies Information and Referral Line,
1-800-322-2588 (voice) or
1-800-833-6388 (TTY Relay)

Parenting Skills or Support: Family Help line, 1-800-932-HOPE (4673), Family Resources Northwest, 1-888-746-9568, Local Community College Classes

Health Tips

Your baby needs several doses of most vaccines to be fully immunized. If your baby has missed any doses, make an appointment to catch up.

Show your baby colorful picture books and talk about the pictures. Sing simple songs and say nursery rhymes over and over.

Signs that your baby is ready to start solid foods:

- She sits up with little or no support.
- She shows that she wants to try your food.
- She can use her tongue to push food into her throat.

Your baby will show you he has had enough to eat. Stop feeding him when he spits food out, closes his mouth, or turns his head away. Let him control how much he eats.

Let your baby begin to learn to drink from a cup. Put water, breast milk, or formula in it. Don't let your baby take a bottle to bed.

Parenting Tips

Give your baby plenty of time to play on his tummy on the floor. Put toys just out of reach so he will try to crawl.

Start playing simple games together like "Peek-a-Boo" and "Pat-a-Cake."

Safety Tips

Make your home safe for your baby before she starts to crawl. You will need to keep doing this for several years.

- Put away small objects and breakable things.
- Tape electric cords to the wall, put covers on outlets.
- Put safety gates at the top and bottom of stairs.
- Store poisons and pills in a locked cabinet.

Baby walkers cause more injury than any other baby product. Instead of a walker, use a seat without wheels or put your baby on his tummy on the floor.

Guidance to Physicians and Nurse Practitioners for Infancy (6 months)

The following highlight EPSDT screens where practitioners often have questions. They are not comprehensive guidelines.

Fluoride Screen

Look for white spots or decay on teeth. Check for history of decay in family. Fluoride supplements should be considered for all children drinking fluoride deficient (<0.6 ppm F) water. Before supplements are prescribed, it is essential to know the fluoride concentration of the patient's drinking water. Once the fluoride level of the water supply has been evaluated, either through contacting the public health officials or water analysis, as well as evaluating other sources of fluoride, the daily dosage schedule can be recommended. Pediatric Dentistry: Reference Manual 1999--00.(21)5.

Hearing Screen

Use clinical judgment.

Lead Screen

Screen infants for these risk factors:

- Live in or frequently visit day care center, preschool, baby sitter's home or other structure built before 1950 that is dilapidated or being renovated.
- Come in contact with other children with known lead toxicity (i.e., blood lead 15ug/dl).
- Live near a lead processing plant or with parents or household members who work in a lead-related occupation (e.g., battery recycling plant).

Developmental Milestones

Always ask about and follow-up on parent concerns about development or behavior. You may use the following screening list, or use the Ages and Stages Questionnaire, the Denver II, the ELMS2 (a language screen), or the MacArthur Communication Development Inventory.

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<u>No head lag when pulled to sit.</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Turns toward voice.</u>
<input type="checkbox"/>	<input type="checkbox"/>	<u>Bears some weight on legs when held.</u>	<input type="checkbox"/>	<input type="checkbox"/>	Transfer object from hand to hand.
<input type="checkbox"/>	<input type="checkbox"/>	<u>Rolls over.</u>	<input type="checkbox"/>	<input type="checkbox"/>	Cuddles.
<input type="checkbox"/>	<input type="checkbox"/>	Imitates speech sounds.	Avoids eye contact.		

Instructions for developmental milestones: At least 90% of infants should achieve the underlined milestones by this age. If you have checked "no" on any two items, or even one of the underlined items, or the boxed item, refer the infant for a formal developmental assessment.

Notes: Immunization schedules are from the Advisory Committee on Immunization Practice of the U.S. Centers for Disease Control and Prevention. **Parents and providers may call Healthy Mothers, Healthy Babies (1-800-322-2588) with questions or concerns on childhood development.**